

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION</b>	1. TRANSMITTAL NUMBER 01-01	2. STATE: <b>ILLINOIS</b>
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: 4-1-01	

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT a. FFY 01 \$ 17,500,000 b. FFY 02 \$ 35,000,000
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, Page 131A, 131B, 131C, 131D, 131E, 131F, 131G, 131H, 131I, 131J	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-A, Page 131A, 131B, 131C, 131D, 131E, 131F, 131G

10. SUBJECT OF AMENDMENT:

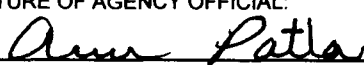
**Inpatient Hospital - Tertiary Care**

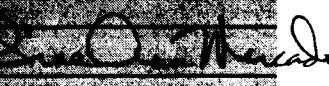
11. GOVERNOR'S REVIEW (Check One)

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL: 	16. RETURN TO:  <b>ILLINOIS DEPARTMENT OF PUBLIC AID 201 SOUTH GRAND AVENUE, EAST SPRINGFIELD, IL. 62763-0001 ATTENTION: John Rupcich</b>
13. TYPED NAME: <b>Ann Patla</b>	
14. TITLE: <b>DIRECTOR</b>	
15. DATE SUBMITTED <b>1/8/01</b>	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: <b>1/10/01</b>	18. DATE APPROVED: <b>1/10/01</b>
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>4/1/01</b>	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: <b>Cheryl A. Harris</b>	Associate Regional Administrator Division of Medicaid and Children's Health
23. REMARKS:	

**RECEIVED**

JAN 10 2001

DMIO - IL/IN/CH

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## STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL  
REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO  
GRANT (MANG)04/01 k. Tertiary Care Payments

Tertiary Care Adjustment Payments shall be made to all eligible hospitals, excluding county-owned hospitals, as described in Chapter II.C.8, and hospitals organized under the University of Illinois Hospital Act, as described in Chapter II.C.8 for inpatient admissions occurring on or after April 1, 2001, in accordance with this Section.

1. Definitions. The definitions of terms used with reference to calculation of payments under this Section are as follows:

a. "Base Period Claims" means claims for inpatient hospital services with dates of service occurring in the Tertiary Adjustment Base Period that were subsequently adjudicated by the Department through December 31, 1999. For a general care hospital that includes a facility devoted exclusively to caring for children and that was separately licensed as a hospital by a municipality before September 30, 1998, Base Period Claims for services that may, in Chapter II.C.3.a., be billed by a children's hospital shall be attributed exclusively to the children's facility. Base Period Claims shall exclude the following types:

- i. Claims for which Medicare was liable in part or in full ("cross-over" claims);
- ii. Claims for transplantation services that were paid by the Department via form C-13, Invoice Voucher; and
- iii. Claims for services billed under categories of service 037 and 038 (exceptional care services)

b. "Case Mix Index" (CMI), for all hospitals qualifying under this subpart K, means the sum of all Diagnosis Related Grouping (DRG) (see Chapter I.F.) weighting factors for Base Period Claims divided by the total number of claims included in the sum, but excluding claims:

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- i. Reimbursed under a per diem rate methodology;  
and
  - ii. For Delivery or Newborn Care.
- c. Case Mix Adjustment Factor" (CMAF) means the following:
- i. For qualifying hospitals located in Illinois that, for Base Period Claims, had a CMI that is greater than the mean:
    - A. CMI of all cost-reporting hospitals, but less than that mean plus a one standard deviation above the mean, the CMAF shall be equal to 0.040;
    - B. CMI plus one standard deviation above the mean of all cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.250;
    - C. CMI plus two standard deviations above the mean of all cost reporting hospitals, the CMAF shall be equal to 0.300.
  - ii. For qualifying hospitals located outside of Illinois that, for Base Period Claims, had a CMI that is greater than the mean:
    - A. CMI of all out-of-state cost reporting hospitals, but less than that mean plus a one standard deviation above the mean, the CMAF shall be equal to 0.020;
    - B. CMI plus one standard deviation above the mean of all out-of-state cost reporting hospitals, but less than that mean plus two standard deviations above the mean, the CMAF shall be equal to 0.125;

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- C. CMI plus two standard deviations above the mean of all out-of-state cost reporting hospitals, the CMAF shall be equal to 0.150.
  - d. "Delivery or Newborn Care" means inpatient hospital care, the claim for which was assigned by the Department to DRGs 370 through 375, 385 through 387, 389, 391 and 985 through 989.
  - e. "Tertiary Adjustment Base Period" means calendar year 1998.
  - f. "Tertiary Care Adjustment Rate Period" means, for fiscal year 2001, the three-month period beginning April 1, 2001, and for each subsequent fiscal year, the twelve-month period beginning July 1.
2. Case Mix Adjustment - The Department shall make a Case Mix Adjustment to certain hospitals, as defined in this subsection (2).
- a. Qualifying Hospital. A hospital meeting all of the following criteria shall qualify for this payment:
    - i. A hospital that had 100 or more Qualified Admissions; and
    - ii. For a hospital located:
      - A. in Illinois, has a CMI greater than or equal to the mean CMI for Illinois hospitals; or
      - B. outside of Illinois, has a CMI greater than or equal to the mean CMI for out-of-state cost-reporting hospitals.

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- b. Qualified Admission. For the purposes of this subsection (2), Qualified Admission shall mean a Base Period Claim excluding a claim:
    - i. Reimbursed under a per diem rate methodology;  
and
    - ii. For Delivery or Newborn Care.
  - c. Case Mix Adjustment. Each Qualifying Hospital will receive a payment equal to the product of:
    - i. The product of the hospital's:
      - A. number of Qualified Admissions; and
      - B. the CMAF; and
    - ii. The sum of the hospital's:
      - A. rate for capital related costs in effect on July 1, 2000; and
      - B. the product of the hospital's CMI raised to the second power and the DRG PPS (Prospective Payment System) (see Chapter II) rate per discharge in effect on July 1, 2000.
3. DRG Adjustment - The Department shall make a DRG Adjustment to certain hospitals, as defined in this subsection (3).
- a. Qualifying Hospital. A hospital that, during the Tertiary Adjustment Base Period, had at least one Qualified Admission shall qualify for this payment.
  - b. Qualified Admission. For the purposes of this subsection (3), Qualified Admission means a Base Period Claim, that was:

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- i. Assigned by the Department to a DRG that:
      - A. had been assigned a weighting factor greater than 3.2000; and
      - B. for which fewer than 200 Base Period Claims were adjudicated by the Department; and
    - ii. Not a claim:
      - A. reimbursed under a per diem rate methodology;
      - B. for Delivery or Newborn Care; or
      - C. with a patient status code of 02 (patient transferred to another short term hospital).
  - c. DRG Adjustment rates. For each Qualified Admission, a Qualifying Hospital will receive a payment equal to the product of:
    - i. The hospital's DRG PPS rate per discharge in effect on July 1, 2000; and
    - ii. The weighting factor assigned to the DRG to which the Qualified Admission was assigned by the Department; and
    - iii. The constant 1.400.
4. Children's Hospital Adjustment - The Department shall make a Children's Hospital Adjustment to certain hospitals, as defined in this subsection (4).
- a. Qualifying Hospitals. A children's hospital, as defined in Chapter II.C.3.a. , shall qualify for this payment.
  - b. Qualified Days. For the purposes of this subsection (4), Qualified Day means a day of care that was provided in a Base Period Claim, excluding a claim:

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- i. For Delivery or Newborn Care;
    - ii. Assigned by the Department to a DRG with an assigned weighting factor that is less than 1.0000;  
or
    - iii. Billed to the Department under category of service 021 (hospital inpatient psychiatric services ) or 022 (hospital inpatient physical rehabilitation services).
  - c. Children's Hospital Adjustment. A Qualifying Hospital shall receive a payment equal to the product of:
    - i. The sum Qualified Days from the hospital's Base Period Claims; and
    - ii. For hospitals with more than 5,000 Qualified Days, \$670; or
    - iii. For hospitals with 5,000 or fewer Qualified Days, \$300
- 5. Primary Care Adjustment - The Department shall make a Primary Care Adjustment to certain hospitals, as defined in this subsection (5).
  - a. Qualifying Hospital. A hospital located in Illinois that has at least one Qualifying Resident.
  - b. Qualifying Residents. The number of primary care residents, as reported on form HCFA 2552-96, Worksheet E-3, Part IV, line 1, column 1, for hospital fiscal years ending September 30, 1997, through September 29, 1998.
  - c. Qualified Admission. For the purposes of this subsection (5), Qualified Admission shall mean a Base Period Claim excluding a claim:
    - i. Billed to the Department under category of service 021 (hospital inpatient psychiatric services ) or 022 (hospital inpatient physical

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- rehabilitation services) and reimbursed under a per diem rate methodology; and
- ii. For Delivery or Newborn Care.
  - d. Primary Care Adjustment. A Qualifying Hospital will receive a payment equal to the product of:
    - i. The number of Qualifying Admissions during the Tertiary Adjustment Base Period;
    - ii. \$4.675; and
    - iii. The quotient of:
      - A. the number Qualifying Residents,
      - B. divided by the number of Qualifying Admissions.
6. Long Term Stay Hospital Adjustment - The Department shall make a Long Term Stay Hospital Adjustment to certain hospitals, as defined in this subsection (6).
- a. Qualifying Hospital. A long term stay hospital, as defined in Chapter II.C.4., that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, shall qualify for this payment.
  - b. Qualified Days. For the purposes of this subsection (6), Qualified Day means a day of care that was provided in a Base Period Claim, excluding claims billed to the Department under category of service of 021 (hospital inpatient psychiatric services ) or 022 (hospital inpatient physical rehabilitation services).
  - c. Long Term Stay Hospital Adjustment Rates. A Qualifying Hospital will receive payments equal to the product of:
    - i. The number of Qualified Days from all Base Period Claims; and

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- ii A constant that:
  - A. for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals plus one standard deviation above the mean, \$300; or
  - B. for a hospital that had a CMI that was greater than or equal to the mean CMI for all long term stay hospitals, but less than one standard deviation above that mean, \$5.

7. Rehabilitation Hospital Adjustment - The Department shall make a Rehabilitation Hospital Adjustment to certain hospitals as defined in this subsection (7).

- a. Qualifying Hospital. A hospital that qualifies for the Rehabilitation Hospital Adjustment under the Critical Hospital Adjustment Payments (CHAP) program, as defined in Chapter XV, shall qualify for this payment.
- b. Qualified Admission. For the purposes of this subsection (7), Qualified Admission shall mean a Medicaid level I rehabilitation admission in the CHAP rate period, as defined in Chapter XV.B., for fiscal year 2001.
- c. Rehabilitation Hospital Adjustment. A Qualifying Hospital shall receive payment as follows:
  - i. For a hospital that had fewer than 60 Qualified Admissions, \$100,000.
  - ii. For a hospital that had 60 or more Qualified Admissions, \$350,000.

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REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG), AND MEDICAL ASSISTANCE-NO  
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8. Tertiary Care Adjustment

- a. The total annual adjustment to an eligible hospital shall be the sum of the adjustments for which the hospital qualifies under subsections (2) through (7) of this Section.
- b. A total annual adjustment amount shall be paid to the hospital during the Tertiary Care Adjustment Rate Period in installments on, at least, a quarterly basis.
- c. For fiscal year 2001 only, one-fourth of the total annual adjustment amount determined under this Section shall be paid during the fiscal year 2001 Tertiary Care Adjustment Rate Period.

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REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG). AND MEDICAL ASSISTANCE-NO  
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07/95 XVI Definitions and Applicability

10/92 A. Payment for hospital inpatient services shall be made only to a hospital or a  
distinct part hospital unit as defined in this Section.

10/92 1. The term "hospital" means:

10/93 a. Any institution, place, building, or agency, public or private,  
whether organized for profit or not-for-profit, which is located in  
the State and is subject to licensure by the Illinois Department of  
Public Health under the Hospital Licensing Act or any institution,  
place, building or agency, public or private, whether organized  
for profit or not-for-profit, which meets all comparable conditions  
and requirements of the Hospital Licensing Act in effect for the  
state in which it is located. In addition, unless specifically  
indicated otherwise, the term "hospital" shall also include:

07/95 i. County-owned hospitals, meaning all county-owned  
hospitals that are located in an Illinois county with a  
population of over three million.

10/93 ii. A hospital organized under the University of Illinois  
Hospital Act.

10/93 2. The term "hospital" shall, in addition to the definitions described in Section A.1.  
above, include a hospital unit that is adjacent to or on the premises of the  
hospital and licensed under the Hospital Licensing Act or the University of Illinois  
Hospital Act.

10/93 3. The term "distinct part hospital unit" means a hospital, as defined in Section A.1.  
above, that meets the following qualification(s):

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